

<b>Case Number:</b>	CM13-0016600		
<b>Date Assigned:</b>	11/06/2013	<b>Date of Injury:</b>	11/03/2012
<b>Decision Date:</b>	02/10/2014	<b>UR Denial Date:</b>	08/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified Internal Medicine and Pulmonary Diseases, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 59-year-old female who reported an injury on 11/3/12. The patient was seen by [REDACTED] on 7/17/13. She complained of 7/10 lower back pain. Physical examination revealed diminished right knee reflexes, paraspinal tenderness, diminished range of motion, and intact sensation. The patient is diagnosed with lumbago, displacement of lumbar intervertebral disc without myelopathy, lumbar facet joint syndrome and hypertrophy, myalgia, and neural foraminal stenosis at L5-S1. Treatment recommendations included epidural steroid injections, a cold unit, a lumbar exercise kit, and continuation of current medications.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**chiropractic treatment twice a week for six weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 58.

**Decision rationale:** The California MTUS guidelines state that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Treatment for the low back is recommended as an option with a therapeutic trial of six visits over

two weeks. With evidence of objective functional improvement, a total of up to 18 visits over 6-8 weeks may be appropriate. As per the clinical notes submitted, the patient's physical examination only revealed tenderness to palpation with slightly diminished range of motion. Documentation of a significant musculoskeletal condition was not provided. Additionally, the request for chiropractic treatment twice a week for six weeks exceeds guideline recommendations of a trial of six visits. As such, the request is non-certified.

**Acupuncture once a week for six weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The California MTUS guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated, and it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The time to produce a functional improvement includes 3-6 treatments with a frequency of 1-3 times per week. Acupuncture treatments may be extended if functional improvement is documented. As per the clinical notes submitted, it was stated on 7/17/13, the patient has been receiving acupuncture twice a week. Documentation of the previous course of therapy with treatment duration and efficacy was not provided for review. Therefore, ongoing treatment cannot be determined as medically appropriate. As such, the request is non-certified.

**LINT for the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines. Page(s): 117-121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 117-121.

**Decision rationale:** The California MTUS guidelines state that neuromuscular electrical stimulation is not recommended; it is used primarily as part of a rehabilitation program following a stroke, without evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from neuromuscular electrical stimulation for chronic pain. As per the clinical notes submitted, there is no documentation of a specific treatment plan with short and long-term goals of treatment with the localized intense neurostimulation therapy unit. There was also no frequency and duration specified in the request. Based on the clinical information received, the request is non-certified.